Organizational Unit: Division of Health Facility Planning

The Division of Health Facility Planning, funded within the Health Care Standards and Surveillance program, is responsible for the administration of the State's Certificate of Need (CON) activities. The State mandated CON program provides a planning mechanism to ensure that health care resources are developed and made available to the public in a comprehensive, coordinated manner which is responsive to the public's health care needs. Each proposal is evaluated based on community need for beds and services, financial feasibility and cost efficiency of the project, and the competence and character of the sponsors. The review of CON applications and determination of need provide a vital step in achieving the Department's goal of quality care for all that is affordable and accessible.

In addition to its responsibility for administering the State's CON program, the Division is involved in activities designed to improve the efficiency of the existing health care network. Through examination of specific facilities and services, the Division makes recommendations regarding the merger or consolidation of facilities and changes in services to more appropriately reflect factors such as utilization and facility financial status.

The Division is composed of two groups: The Health Facility Planning Group and the Certificate of Need Review Group.

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The Health Facility Planning Group is composed of two bureaus:

1. Bureau of Health Facility Planning

2. Bureau of Architectural and Engineering Facility Planning

The Certificate of Need Review Group is composed of two bureaus and one unit:

1. Bureau of Facility and Service Review

2. Bureau of Financial Analysis and Review

3. Project Management Unit

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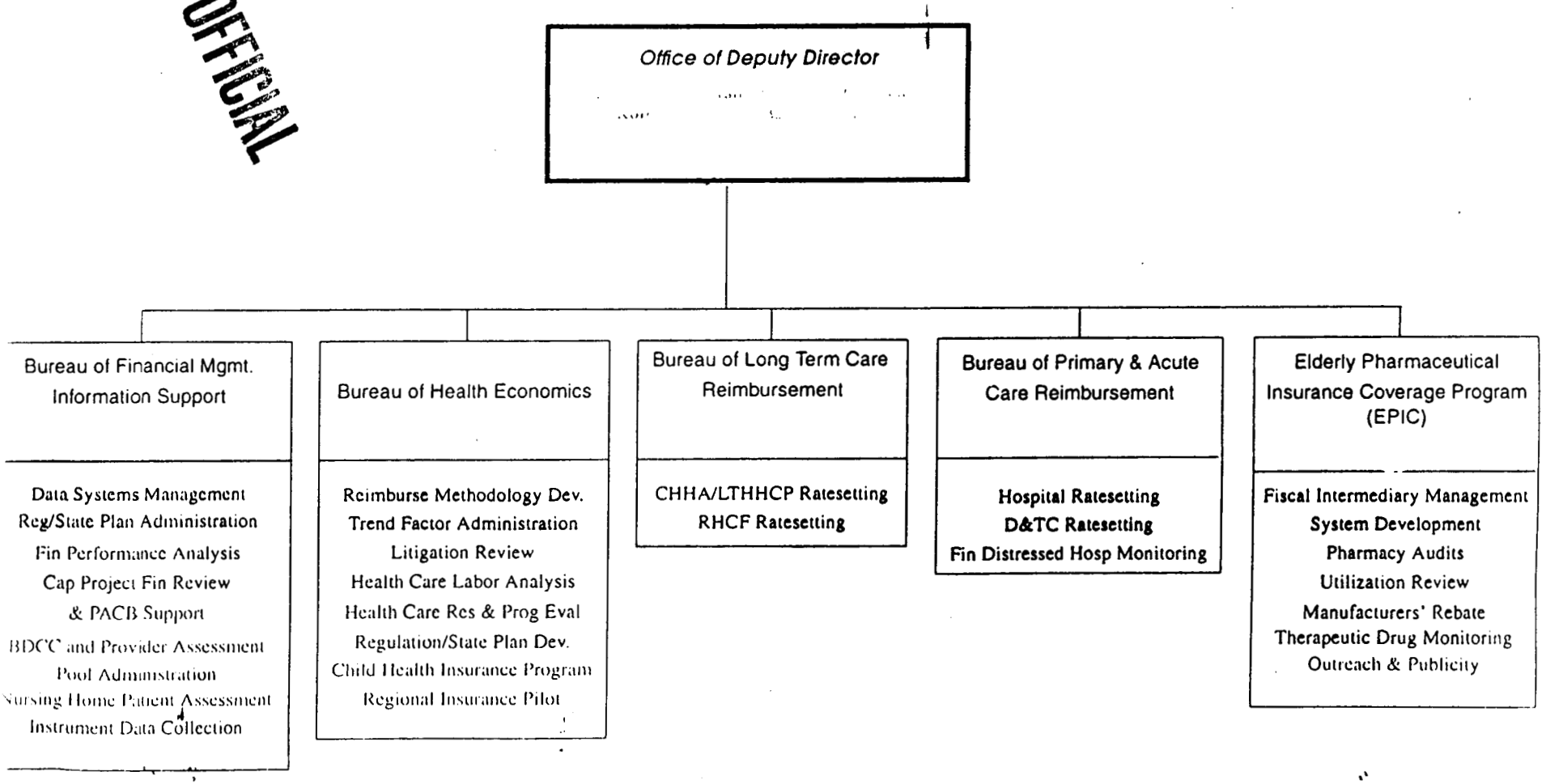
Division of Health Care Financing



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DIVISION OF HEALTH CARE FINANCING

The Division of Health Care Financing is organizationally responsible for ensuring that health care resources are most appropriately allocated. Financial management of New York State's health care system is accomplished through a variety of activities. They include developing reimbursement methodologies, setting third party reimbursement rates, administering State revenue collection programs generated through various assessments charged to health care providers, and reviewing the financing mechanisms of proposed health facility construction and expansion projects. Alternative health care financing mechanisms that offer potential cost control incentives and savings are also examined, tested and evaluated.

The following units are responsible for carrying out the duties of the Division:

1. Bureau of Health Economics
2. Bureau of Primary and Acute Care Reimbursement
3. Bureau of Financial Management and Information Support
4. Bureau of Long Term Care Reimbursement

THE MAJOR RESPONSIBILITIES OF THE DIVISION INCLUDE:

- Calculating and/or promulgating and approving rates of payment for hospitals, residential health care facilities, diagnostic and treatment centers, home health agencies, and other Article 28, 36, 40, 43, and 44 certified facilities.
- Adjudicating appeals to rates of payment consistent with regulations and statute.
- Developing and evaluating new and alternative financing methods for health care providers and insurers. These financing methods include improving methods of pricing health care services, refining patient provider encounters, and examining capital financing methods and utilizing insurance vehicles for providing health care services for the uninsured and underinsured.
- Administering several grant programs for global budgeting, health networks and health care demonstrations.
- Developing and implementing sponsored health care financing research activities.

- Establishing and administering the financing reforms detailed in the Health Care Reform Act of 1996. Developing policies, procedures and protocols that will, for the first time, allow New York to move to negotiated rates for hospital care and will continue support of public policy priorities including uncompensated care, graduate medical education and numerous health care initiatives.

- Administering approximately $2.0 billion in pooled funds financed through health care provider and insurer assessments and surcharges for medically indigent subsidies, various health care project initiatives, graduate medical education and physician excess malpractice coverage.

- Administering collection of statutory assessments on health care providers pertaining to the Health Facility Cash Receipts Assessment Program, and the HMO Differential.

- Maintaining the Patient Review Instrument (PRI) processing system, including collection of data via electronic mail, correction of data, auditing of data, assignment of Resource Utilization Group (RUG), and updating of Residential Health Care Facility (RHCF) rates to reflect changes in case mix index (CMI).

- Collecting cost report data via electronic mail for five provider groups; hospitals, RHCFs, Diagnostic & Treatment Centers (D&TCs), Certified Home Health Agencies (CHHAs), and Long Term Home Health Care Programs (LTHHCPs).

- Providing financial analysis services to State mortgage loan programs which provide construction financing to non-profit nursing homes and hospitals.

- Designing and evaluating payment methodologies for hospitals, nursing homes and ambulatory care programs which includes conducting research studies to support Departmental policy recommendations concerning payment for and delivery of health care services; preparing Title XIX (Medicaid) State Plans for health care services which are submitted to the federal government to procure Medicaid federal financial participation; drafting regulations to implement reimbursement methodologies; preparing responses to litigation brought against the Department by providers pertaining to reimbursement methodologies; responding to inquiries from industry, other State agencies, legislative staff and the general public regarding the Medicaid financing systems; and, developing grant applications to procure outside funding for research on financing issues and economic analyses of health care systems.

- Coordinating the development of all new Medicaid Program finance regulations and providing administrative services to the State Hospital Review and Planning Council, Fiscal Policy Committee and Medical Advisory Committee.

- Ensuring compliance with Federal statutory requirements relating to the State's provider tax programs. This includes preparation of any necessary waiver applications, and corresponding statistical testing and analysis, pursuant to Federal law.

- Ensuring compliance with Federal Disproportionate Share payment limitations. This includes projecting hospital distributions, Medicaid and uninsured net revenue/losses and implementing such limits into the pool distribution process.

- Monitoring the Receivership Program and its related Receivership Fund, calculating capital costs, monitoring the Article 28-A Mortgage Program and controlling its related Operating Escrow Account activities.

- Monitoring and evaluating the uniform physician billing form and electronic claims submission legislative requirements, including coordination of the activities of the Physician Claim Task Force.

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Organizational Unit: Elderly Pharmaceutical Insurance Coverage Program (EPIC)

The Elderly Pharmaceutical Insurance Coverage (EPIC) program provides assistance to low and moderate income elderly through subsidizing the costs of their prescription medications. As of March 1990, over 76,000 seniors were enrolled in EPIC. Since the program began in October 1987, EPIC has saved these older New Yorkers over $52 million on the costs of their medications.

The program performs outreach and promotion to inform seniors about the program, enrolls eligible persons, supervises a large contractual operation which processes payments to pharmacies and participants, and performs audits of both the contractor and the providers to assure the fiscal integrity of program operations. In addition, a utilization review function assists in the detection of potential fraud or abuse, research is completed on various aspects of program participation and utilization, and a process for reconsideration and fair hearing is maintained to address participant and provider disputes.